Case Report

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Website: www.jfcmonline.com

DOI: 10.4103/jfcm.JFCM_512_20

Gender dysphoria in Saudi Arabia

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Abstract:

Gender dysphoria is defined as a multisystemic medical condition where a person has marked discordance between their biological sex and the gender they identify with. Here we report a case of 44-year-old male who presented to the family medicine clinic as a known case of gender dysphoria. Patient was severely distressed about his life and was actively seeking a solution to his problem. The patient requested that the treating physician addresses him as a female and uses feminine proverbs while speaking with him. On examination of genitalia, testicles were smaller than normal for his age and sex. Several abnormalities were found including low levels of testosterone, luteinizing hormone, and follicle-stimulating hormone, and elevated prolactin levels. Abdominal and pelvic ultrasound showed that the internal organs were all normal size and consistency. No uterus, ovaries or rudimentary female reproductive organs were found. Testicular ultrasound revealed atrophy of both testicles and weak peripheral testicular vascularity were noted. CT scan with contrast revealed severe hepatic steatosis as well as bilateral gynecomastia. Primary care physicians need to be aware of gender-related disorders as well as the importance of early recognition of these emerging disorders. A multidisciplinary approach is needed to manage these disorders.

Keywords:

Dysphoria Saudi Arabia, dysphoria, gender, transgender identity disorders

Introduction

The term gender dysphoria has now replaced the term gender identity disorder that was previously used in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-4-TR).[1] According to the fifth edition of the DSM-5, gender dysphoria is defined as a multisystemic medical condition in which there is a marked discordance between the biological sex a person is assigned and the gender they identify with. This discordance causes grave distress in many areas of these patients' lives such as their psychological, social, and interpersonal relationships with family and friends. Patients with gender dysphoria often express the desire to be addressed and treated as the gender they identify with rather than the sex they were assigned with at birth.[2] It is very important that the primary healthcare practitioners recognize the dilemmas the patients with gender dysphoria contend with, as well as their own dilemmas in managing these patients within the dictates of Islamic guidance.[3]

Case Report

A 44-year-old phenotypical male patient, not known to have any chronic medical illnesses, presented to the family medicine clinic as a known case of gender dysphoria. The patient also had symptoms of depression and was severely distressed about his life and was actively seeking a solution to his problem. The patient requested that the treating physician addresses him as a female and uses a feminine alias with him as well as feminine proverbs while speaking with him.

The patient's birth had been uneventful, and there had been no significant medical

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Received: 24-11-2020
Revised: 05-12-2020
Accepted: 27-12-2020
Published: 08-05-2021

How to cite this article: Alqahtani HA, Motabgani SM. Gender dysphoria in Saudi Arabia. J Fam Community Med 2021;28:133-6.

issues. The patient grew up in a household with other male and female siblings and was raised as a male but had secretly identified himself as a female since early childhood. The patient liked playing with feminine toys such as Barbie dolls, enjoyed dressing up in female clothes, and enjoyed wearing artificial female hair attachments. The patient studied in an all-male elementary school and often felt isolated with little sense of connectedness. The patient discontinued intermediate school because he could neither fully bring himself to integrate with other males nor fit into to an all-male environment. The patient would have preferred to attend an all-girl school, form friendships with girls, and be involved in feminine hobbies and interests. The patient recalled an incident of physical harassment that occurred during his childhood but denied any incidents of sexual abuse.

The patient was faced with a difficult situation in his family, for it was difficult for them to accept his feminine behavior and mannerisms. The patient had had an unsuccessful marriage to a female partner, but it had ended in divorce because of his impotence and sexual dysfunction. The patient had a history of 4–6 suicidal attempts.

The occupational history included being a taxi driver and ladies' hairdresser in many different countries. As a hairdresser, he would dress up as a female and take on a female identity. Currently, the patient works in a private company in Saudi Arabia as a male and has an employer who is very understanding of his situation. He now lives alone with no partners or roommates and prefers to keep his interactions with other people to the barest minimum.

The patient started taking over-the-counter combined oral contraceptive pills 13 years ago with neither a prescription nor a physician's supervision. He denies using any recreational drugs. However, the patient admitted to smoking a packet of cigarettes a day and to being an occasional drinker.

The patient had low mood, had no interest and had symptoms of depression, but denied any history of psychosis, delusions, and hallucinations. He was assessed for depression during each visit to the clinic using the Patient Health Questionnaire-9 depression scale. He was found to have mild-to-moderate depression but no suicidal thoughts during those visits. However, he refused the antidepression medications.

The patient's vital signs were within the normal range for his age and sex. He sat comfortably on the bed, was alert, conscious, and not in any apparent pain or respiratory distress. The general appearance was that of a male, but he lacked facial hair and had no hair on the visible parts of his body. Examination of the chest revealed gynecomastia. Auscultation of both lungs and heart was within normal limits, and no added sounds were noticed. His abdomen revealed a lack of normal male pattern of hair distribution. Abdomen was soft, lax, no tenderness, no masses or organomegaly was noticed. Genitalia examination revealed a normal-sized penis, normal scrotum, but the testicles were smaller than normal for his age and sex.

The patient's hormonal panel revealed several abnormalities including low levels of testosterone, luteinizing hormone, and follicle-stimulating hormone. Other abnormalities included elevated levels of prolactin. His thyroid-stimulating hormone, T4, and estradiol were all within normal limits. Abdominal and pelvic ultrasound showed that the internal organs were all normal size and consistency. No masses were noted. No uterus, ovaries or rudimentary female reproductive organs were found. Testicular ultrasound revealed bilaterally descended testes. However, atrophy of both testicles and weak peripheral testicular vascularity were noted. Enhanced computed tomography scan with contrast of the abdomen and pelvis revealed severe hepatic steatosis as well as bilateral gynecomastia. Finally, chromosomal analysis revealed a genotypical male with a 46XY chromosomal constitution.

Gender dysphoria with moderate depression was diagnosed by means of a comprehensive history and clinical presentation.

Discussion

To manage this patient, a multidisciplinary approach was required. This included his primary care physician, a psychiatrist, a psychologist, and an urologist. These medical professionals of different specialties were involved in evaluating, following up, and establishing the diagnosis of gender dysphoria.

The patient was first referred to a urologist and a psychiatrist for further evaluation as the genotype of the patient was still not determined. However, once the results of the karyotype confirmed that the patient had a phenotypical composition of 46XY chromosomes, and the sex was established, he was referred to a clinical psychologist for further evaluation and management. He remains under his care till now.

Patients in Saudi Arabia who have gender dysphoria have a dilemma as all parties involved from the medical

professionals to the patients eventually face the issue of what is considered acceptable and what is religiously prohibited by Islamic law with regard to gender dysphoria and sex reassignment surgery (SRS).

SRS is not an available option in Saudi Arabia. The problem is whether it should be granted to these patients under exceptional circumstances or whether the patient should seek other options in countries that do offer it. The consequences of SRS affect various aspects of the patients' life not only from a legal point of view such as the need to change or edit passports, national ID cards, certificates, and all other legal documents but also from the religious standpoint such as the use of prayer attire since male and female prayer attires in Islam differ. There is also the question of the distribution of inheritance, the cessation of prayer and the holy pilgrimage for females during menstruation, issues of marriage, divorce, mourning periods after the death of a husband, and many other religious aspects that differ with regard to the two sexes in Islam.[4]

Another dilemma the medical practitioners have when considering SRS for a patient with gender dysphoria is the question of overall satisfaction after the reassignment surgery should the patient be granted permission by local authorities to do so. Some studies have indicated overall satisfaction with SRS, from male to female[5] or female to male.[6] However, owing to the variations in religious, racial, and cultural backgrounds, the results of SRS may not be satisfactory to the patients and may even worsen the depressive symptoms in patients of middle-eastern origins.

Another point that needs to be addressed as regards gender dysphoria in Saudi Arabia is the fact that some homosexual patients who are fully aware of their sexual preferences assume the pose of having gender dysphoria in order to justify their sexual proclivity to continue with their relationships with other males or seek male attention. This is prohibited under Islamic laws and regulations. Family physicians may be confused in cases like this and erroneously classify homosexual patients as gender dysphoria.

More studies are needed in order to estimate the prevalence of gender dysphoria in Saudi Arabia, and to provide guidance and guidelines for physicians who are directly involved in managing such cases to help them give the best care to these patients. We also recommend the formation in different regions of the kingdom, local committees consisting of Islamic scholars, medical professionals, and social workers who can help by providing knowledge and assistance to both the patients and their treating teams with regard to the individual cases and treatment options.

Conclusion

Gender dysphoria is a complex medical condition. Physicians may be in a quandary as to how to deal with patients who are suffering from this condition and are often unsure as to how to proceed to provide the best supportive care in such circumstances.[3]

Primary care physicians need to be aware of gender-related disorders as well as the importance of early recognition of these emerging disorders. A multidisciplinary approach with a primary care physician, a psychiatrist, a psychologist, an urologist, an endocrinologist, a gynecologist, and in some circumstances, a social worker is needed to manage these disorders. Islamic religious dictates, the national regulations, and cultural factors need to be borne in mind when dealing with these critical issues.

Primary care physicians also need to be aware of the comorbidities associated with gender dysphoria such as depression and anxiety, which are the most prevalent in such patients and need to be screened for them.[7] This is particularly important in a patient who has made multiple attempts at suicide as in the case of the patient presented.

Declaration of patient consent

The authors certify that they obtained the appropriate consent from the patient. In the forms, the patient indicated his consent for his clinical information to be reported in a medical journal. The patient understood that his name would not be published.

Acknowledgment

We are grateful to Dr. Abdullah Aljoudi, Community Medicine and Biomedical Ethics Consultant, King Fahd University Hospital, for his guidance and general support in preparation of this case report.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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